Park (A. V.)

A Case of Ante-Partum Hæmorrhage at Term. Recovery.

BY

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OF CHICAGO.

MEMBER OF THE AMERICAN MEDICAL ASSOCIATION, CHICAGO MEDICO-LEGAL SOCIETY, CHICAGO MEDICAL SOCIETY, ETC.

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A CASE OF ANTE-PARTUM HÆMORRHAGE AT TERM. RECOVERY.

On the morning of August 5, 1886, I was called to see Mrs. S., age 37 years, a large and powerfully-built American-born Irish woman, cultured and intelligent for one in her station of life; she gave me this history:

This was her ninth confinement, she had also suffered six miscarriages. Professor Daniel T. Nelson, her family physician, was compelled to use instruments on one occasion; the child was large and healthy and she made a good recovery; she had received no falls or injuries since carrying this child, to her knowledge. There was no history or evidence of specific disease. Before I finished questioning she remembered a few evenings since of running against some obstruction in the back-yard; this gave her a slight shock just at the time, but she paid no attention to it. The evening previous to my call, just as she had retired for the night, she said she was taken with a severe hæmorrhage which lasted for some time, and the amount of blood frightened her, and she called in a physician. The hæmorrhage soon stopped and her pains were nothing to speak of. There had been some propulsive efforts throughout the night, and in the morning they were simply teasing and prevented her from securing any rest. She suffered no real or hard labor pains and not a particle of hæmorrhage during the night.

I made a careful examination of the bedding and of the soiled clothing which had been removed the evening before, and found them wet and heavy and blood-stained, but was unable to find clots of arterial blood or any evidence of a severe or continued uterine hæmorrhage. The pulse was regular, the volume and strength good, respiration and temperature normal; vaginal examination revealed a rigid os uteri and situated high in the pelvis, and directed back-

ward so it pointed toward the cavity of the sacrum; the os uteri in this situation would have escaped any ordinary examination; there was no dilatation. I was satisfied that the pains were not true labor pains and I gave tinctura opii deodarata in fifteen minim doses, and to repeat in an hour or two if necessary.

3 P.M.—I was sent for in great haste, and upon my arrival found that there had been expulsive efforts during the past hour, but she was again quite easy and free from severe pain. I again examined the os and found it more soft and was enabled to insinuate my index finger, and by careful pressure with my left hand over the fundus uteri I could distinguish the head presenting. To satisfy myself as to the true character of the pains I remained at the bedside; the pains were irregular, sometimes severe, again they would be but slight. I examined the condition of the os uteri during the period of the pain, and found that the pains had no effect upon the cervix which remained undilated and flaccid, and the membranes did not become prominent or tense. The bowels had moved early in the day and a light meal taken at 12 M. Advised the continuance of the anodyne at once and again in two hours. This would control the severity of the pains and would lessen the rigidity of the os.

11 P.M.—Found the patient suffering true labor pains, pain in the back, the os soft and dilated to the size of a twenty-five cent piece; the head at the brim of the pelvis; the edges of the os thinned; the cervix rigid with each pain; there was no bag of water to act as a cushion. 12, 1 and 2 o'clock the labor was much the same, and was what would be termed a tedious labor; the liquor amnii having all escaped with the so-called hæmorrhage and each expulsive effort accomplished but little.

2:30 A.M.—The pains are more regular, the patient is warm and perspiring; the face is flushed and the carotids stand out round and full with each parturient effort; everything seemed favorable for an early termination of labor. Soon I noticed that the pains were not as propulsive, yet they were equally as painful; complained of great thirst, constantly call-

ing for water; she became uneasy and restless, the face losing its ruddy color and the lips bleached; the pulse feeble, rapid and easily compressible. For the first time in nearly four years of active obstetric practice I was brought to the full realization of the great danger of concealed or ante-partum hæmorrhage. There was but one thing to be thought of, and that was to deliver at once and in the shortest time practicable. I placed the patient across the bed, the head and shoulders without bolsters, the nates drawn forward over the edge of the bed, the knees well flexed and held by assistants. With the first pain I ruptured the membranes; this was followed with a gush of blood, a small amount however. I applied the forceps; the head was at the superior straight, and with the second pain I made gentle and careful traction, observing the well-known law which governs the obstetricians in the high forceps operation, and delivered a still-born child which bore all the evidences of having been dead at least six hours; gave child to the nurse and applied my left hand over the fundus uteri and made gentle pressure; soon the uterus commenced to contract and expel its contents; the blood and blood-clots that were thus forced out filled a common wash basin. The placenta was high up and normally situated on the posterior wall; with my left hand still on the fundus I experienced no trouble in reaching and removing the placenta; with this accomplished, all hæmorrhage ceased, ergot was given and gentle pressure continued over the fundus uteri for a short period, stimulants given and patient made as comfortable as possible; pulse 140 to 145, weak and compressible, thirst continued for a few hours.

Complicating this case we had hæmorrhoids with prolapse of rectum and during the real labor pains it was nearly impossible to retain the hæmorrhoids within the sphincters; after delivery they were cleansed and returned with the replaced bowel within the sphincters and retained with a T bandage and compress; suppositories of opium and tanic acid gave quick relief. Patient made a rapid and easy re-

covery; was sitting up on the tenth day after confinement.

From all the phenomena observed I believe that the hæmorrhage was caused from a partial separation of a normally situated placenta. I also believe that the head of the child acted very like a ball valve and prevented the escape of the blood externally. I further believe that the blood or a portion of it found its way within the amniotic cavity, this would account for the amniotic fluid being colored with blood, also for the slight hæmorrhage that followed the mechanical rupture of the membranes previous to delivery. There must have been a rupture of the membranes high up and out of reach that allowed the escape of all the liquor amnii, for the membranes were intact, at least those presenting as far as they could be reached by a digital examination previous to delivery.

From statistics published by Churchill I find that out of 218 cases of accidental hæmorrhage thirty-two proved fatal, or one in six.[1]

I quote from Lusk's third and last edition:[2] "The circumstances under which concealed hæmorrhage takes place are given by Goodell[3] as follows: (a) When the placenta is centrally detached and the blood accumulates in the cul-de-sac formed by the firm adhesion of its margins to the uterine wall. (b) When the placenta is so detached that the blood escapes into the uterine cavity behind the membranes near the fundus. (c) When membranes are ruptured near the detached placenta and the effused blood mingles with the liquor amnii. (d) When the presented part of the fœtus so accurately plugs up the maternal outlet that no existing hæmorrhage can escape externally. I have had a case where after labor I removed at least a basinful of firm clots from the uterine cavity, and yet both mother and child survived. In my own case to which I have referred, the Barnes dilator acted capitally, not only enabling

[1] Churchill's System of Midwifery, p. 454.
[2] Lusk, Science and Art of Midwifery, p. 599-600.
[3] Goodell, on "Concealed Accidental Hæmorrhage of the Gravid Uterus." (Am. Jour. of Obstet., Aug., 1886, p. 281.) This paper serves as a mine from which most subsequent writers have drawn their data.

me to expand the cervix, but exciting the uterus to contract vigorously.

"The serious symptoms set in after the membranes were ruptured and compelled me to deliver with forceps. In another case I should certainly first dilate, and, after rupture of the membranes should chose version and speedy extraction, and should avail myself of a skilled assistant, whose duty it should be to compress the uterine walls externally during the act of delivery.

"In case of internal hæmorrhage occurring during the progress of the labor the treatment will depend upon the stage of the labor and the amount of blood lost, judging by its effect. If the patient be in danger of sinking, and the os uteri dilatable but the head within the uterus, there can be no doubt that we must deliver by turning; but if the loss be moderate we may perhaps afford to wait until the head descends into the cavity of the pelvis, and in all cases where it is within reach of the forceps they should be used for immediate delivery, if the case be mechanically suitable. But little hesitation need be felt on account of the child in deciding upon the mode of delivery as it is lost in almost every case of extreme hæmorrhage.[4]"

We know from experience that a diagnosis of this condition is not easily made, yet the symptoms are so evident that one can only think of an internal hæmorrhage. The prognosis for the child is very bad, because, as a rule, it dies unless delivery be very speedily accomplished by nature or by art. For the mother the prognosis also is unfavorable and much more so than in placenta prævia.[5]

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The bleeding may show itself externally when the membranes are sufficiently ruptured to admit of the escape, or it may go on insidiously within the uterine cavity without escaping externally, to a large, and even fatal extent. . . . . I have known it to result from the patient stretching to reach something off a high

[4] Churchill's System of Midwifery, p. 454.
[5] Schroeder, Manual of Midwifery, p. 308.

shelf; it has also resulted rom an over-exertion, . . . and it not infrequently occurs from a journey over a rough road or in an uneasy conveyance. Railway travel has also a similar effect. (Meadows' Manual of Midwifery, p. 384.)

Dr. Johnson, late Master of the Dublin Lying-in Hospital, reports two cases, in either of which was there any external hæmorrhage whatever; and the separation of the placenta seemed to have been produced in one by outward violence, but in the other it was apparently of spontaneous origin. Both of these patients sank under the loss of blood, and upon post-mortem examination nearly the same appearances were found in each, viz.: The placenta, except at its extreme margin, was entirely detached from the uterus, and the cavity or interspace between the two contained an enormous quantity of coagulated blood. (Murphey's Midwifery, 2d edit., p. 441.)

Out of Goodell's 106 cases, no less than 64 mothers died. This excessive death-rate is no doubt partly due to the fact that extreme prostration so often occurs before the existence of hæmorrhage is suspected, and partly to the accident generally happening in women of weakly and diseased constitutions. The prognosis to the child is still more grave. Out of 107 children only 6 were born alive. The almost certain death of the child may be explained by the fact that when blood collects between the uterus and the placenta, the fœtal portion of the latter is probably lacerated, and the child then also dies from hæmorrhage. . . . . If we have any reason to suspect concealed hæmorrhage, the sooner the uterus is emptied the better. If the os be sufficiently dilated, the best practice will be to turn without further delay, using the bi-polar method if possible. If the os be not open enough, a Barnes bag should be introduced, while firm pressure is kept to prevent uterine accumulation. Should the head be low down in the pelvis, it may be easier to complete labor by means of the forceps. (Playfair, pp. 399 to 402.)